

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>12 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>111 Bells Lane</u>				d. STREET ADDRESS <u>111 Bells Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Iena</u> Last <u>Alexander</u>				4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-1899</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Wesley</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mary Trailer, 111 Bells Lane Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the rectum</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10-30-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Griffin & Co. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cecil, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin R. Bell</u>				ADDRESS <u>Wilkes, Md.</u>		24a. REGD BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>H. A. Shroyer</u>				DATE <u>11-5-1957</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		TIME OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF MEDICAL EXAMINER [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF EXAMINATION [Faint text]		TIME OF EXAMINATION [Faint text]		PLACE OF EXAMINATION [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF MEDICAL EXAMINER [Faint text]	

BUREAU V. S.

NOV 5 1951

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Item 18 Film 221 10-23-57 ans

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10523

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton		LENGTH OF STAY (in this place) 2 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Charlestown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Elmer		(Middle) Glenn		(Last) Anderson		(Month) (Day) (Year) October 7 19 57	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 12, 1936	9. AGE last birthday 21 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IBM Operator		10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Prov. Gr.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Glenn J. Anderson				14. MOTHER'S MAIDEN NAME Edna Funk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 215-32-6081		17. INFORMANT & ADDRESS Mrs. Clarence Shockley, Charlestown, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
274x IMMEDIATE CAUSE (A) Acute pharyngitis						2 days	
ANTECEDENT CAUSE(S) DUE TO (B) Addisons Disease						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Atrophy of adrenals, cause undetermined						-	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						-	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5:00 p.m., 19 57, to 7:00 p.m., 19 57, that I last saw the deceased alive on 7:00 p.m., 19 57, and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
SIGNATURE Klaus H. Thueker				ADDRESS (Street, city, town, state) North East, Md.		DATE SIGNED 7:00 '57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 10, 1957		NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		LOCATION (City, town, or county) (State) Bel Air, R.D., Maryland	
24. REC'D BY REGISTRAR DATE 10/10/57		REGISTRAR'S SIGNATURE F R Frazer		25. FUNERAL DIRECTOR'S SIGNATURE V. A. Patterson, Son, Perryville, Md.			

CERTIFICATE OF DEATH

10822

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF VENDOR

19. SIGNATURE OF BURIAL

20. SIGNATURE OF INTERMENT

21. SIGNATURE OF RECORD

22. SIGNATURE OF INDEX

23. SIGNATURE OF FILE

24. SIGNATURE OF COPY

25. SIGNATURE OF RETURN

26. SIGNATURE OF FOLDER

27. SIGNATURE OF BOX

28. SIGNATURE OF SHEET

29. SIGNATURE OF LABEL

30. SIGNATURE OF TAB

31. SIGNATURE OF DIVISION

32. SIGNATURE OF SECTION

33. SIGNATURE OF BRANCH

34. SIGNATURE OF OFFICE

35. SIGNATURE OF ROOM

36. SIGNATURE OF DESK

37. SIGNATURE OF CHAIR

38. SIGNATURE OF TABLE

39. SIGNATURE OF FLOOR

40. SIGNATURE OF WALL

41. SIGNATURE OF CEILING

42. SIGNATURE OF DOOR

43. SIGNATURE OF WINDOW

44. SIGNATURE OF LIGHT

45. SIGNATURE OF HEAT

46. SIGNATURE OF COOL

47. SIGNATURE OF DRY

48. SIGNATURE OF WET

49. SIGNATURE OF CLEAN

50. SIGNATURE OF DIRTY

51. SIGNATURE OF ORDER

52. SIGNATURE OF DISORDER

53. SIGNATURE OF NEAT

54. SIGNATURE OF UNNEAT

55. SIGNATURE OF TIDY

56. SIGNATURE OF UNTIDY

57. SIGNATURE OF COMFORT

58. SIGNATURE OF UNCOMFORT

59. SIGNATURE OF SLEEP

60. SIGNATURE OF AWAKE

61. SIGNATURE OF REST

62. SIGNATURE OF NO REST

63. SIGNATURE OF HEALTH

64. SIGNATURE OF UNHEALTH

65. SIGNATURE OF LIFE

66. SIGNATURE OF DEATH

67. SIGNATURE OF SURVIVAL

68. SIGNATURE OF NON-SURVIVAL

69. SIGNATURE OF RECOVERY

70. SIGNATURE OF NO RECOVERY

71. SIGNATURE OF IMPROVEMENT

72. SIGNATURE OF NO IMPROVEMENT

73. SIGNATURE OF PROGRESS

74. SIGNATURE OF NO PROGRESS

75. SIGNATURE OF STATION

76. SIGNATURE OF NO STATION

77. SIGNATURE OF STABLE

78. SIGNATURE OF UNSTABLE

79. SIGNATURE OF FIRM

80. SIGNATURE OF UNFIRM

81. SIGNATURE OF SURE

82. SIGNATURE OF UNSURE

83. SIGNATURE OF CONFIDENT

84. SIGNATURE OF UNCONFIDENT

85. SIGNATURE OF CALM

86. SIGNATURE OF UNCALM

87. SIGNATURE OF QUIET

88. SIGNATURE OF UNQUIET

89. SIGNATURE OF PEACE

90. SIGNATURE OF NO PEACE

91. SIGNATURE OF ORDER

92. SIGNATURE OF NO ORDER

93. SIGNATURE OF NEAT

94. SIGNATURE OF UNNEAT

95. SIGNATURE OF TIDY

96. SIGNATURE OF UNTIDY

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132. SIGNATURE OF NO ORDER

133. SIGNATURE OF NEAT

134. SIGNATURE OF UNNEAT

135. SIGNATURE OF TIDY

136. SIGNATURE OF UNTIDY

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138. SIGNATURE OF UNCOMFORT

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140. SIGNATURE OF AWAKE

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144. SIGNATURE OF UNHEALTH

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149. SIGNATURE OF RECOVERY

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152. SIGNATURE OF NO IMPROVEMENT

153. SIGNATURE OF PROGRESS

154. SIGNATURE OF NO PROGRESS

155. SIGNATURE OF STATION

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170. SIGNATURE OF NO PEACE

171. SIGNATURE OF ORDER

172. SIGNATURE OF NO ORDER

173. SIGNATURE OF NEAT

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175. SIGNATURE OF TIDY

176. SIGNATURE OF UNTIDY

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180. SIGNATURE OF AWAKE

181. SIGNATURE OF REST

182. SIGNATURE OF NO REST

183. SIGNATURE OF HEALTH

184. SIGNATURE OF UNHEALTH

185. SIGNATURE OF LIFE

186. SIGNATURE OF DEATH

187. SIGNATURE OF SURVIVAL

188. SIGNATURE OF NON-SURVIVAL

189. SIGNATURE OF RECOVERY

190. SIGNATURE OF NO RECOVERY

191. SIGNATURE OF IMPROVEMENT

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193. SIGNATURE OF PROGRESS

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210. SIGNATURE OF NO PEACE

211. SIGNATURE OF ORDER

212. SIGNATURE OF NO ORDER

213. SIGNATURE OF NEAT

214. SIGNATURE OF UNNEAT

215. SIGNATURE OF TIDY

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228. SIGNATURE OF NON-SURVIVAL

229. SIGNATURE OF RECOVERY

230. SIGNATURE OF NO RECOVERY

231. SIGNATURE OF IMPROVEMENT

232. SIGNATURE OF NO IMPROVEMENT

233. SIGNATURE OF PROGRESS

234. SIGNATURE OF NO PROGRESS

235. SIGNATURE OF STATION

236. SIGNATURE OF NO STATION

237. SIGNATURE OF STABLE

238. SIGNATURE OF UNSTABLE

239. SIGNATURE OF FIRM

240. SIGNATURE OF UNFIRM

241. SIGNATURE OF SURE

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244. SIGNATURE OF UNCONFIDENT

245. SIGNATURE OF CALM

246. SIGNATURE OF UNCALM

247. SIGNATURE OF QUIET

248. SIGNATURE OF UNQUIET

249. SIGNATURE OF PEACE

250. SIGNATURE OF NO PEACE

251. SIGNATURE OF ORDER

252. SIGNATURE OF NO ORDER

253. SIGNATURE OF NEAT

254. SIGNATURE OF UNNEAT

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256. SIGNATURE OF UNTIDY

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the office of the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

10524

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun x2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Union Hospital				d. STREET ADDRESS West Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Everett Baird, Jr.				4. DATE OF DEATH Month Day Year 10 14 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1935		9. AGE (In years last birthday) 21 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Surveyor		10b. KIND OF BUSINESS OR INDUSTRY Road Construction		11. BIRTHPLACE (State or foreign country) Rising Sun, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Everett Baird, Sr.				14. MOTHER'S MAIDEN NAME Bertha Mae Drennen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-32-5679		17. INFORMANT Address Joseph E. Baird, Rising Sun, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull. Amputation of right ear and 812x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. multiple contusions and abrasions over body and DUE TO extremities (c) extremities						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was hit by a car while at work on the road.					
20c. TIME OF INJURY Month, Day, Year 7-35 a.m. 10 14 57		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 273		20f. (City or town) (County) (State) Rising Sun R.D. Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-14-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-57		22c. NAME OF CEMETERY OR CREMATORY Brookveiw		22d. LOCATION (City, town, or county) (State) Rising Sun Cecil Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed, Rising Sun, Md. Info. from B.P.				ADDRESS et		24a. REC'D BY REGISTRAR 16 1957	
				24b. REGISTRAR'S SIGNATURE R. K. Frazee			

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-1-1957

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BUREAU V. S.

OCT 16 1957

RECEIVED

10-1-1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10525

10525

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 Vol-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 2001 Ashland Ave	
3. NAME OF DECEASED (Type or print) First Clarence Middle Wm. Last Baker		4. DATE OF DEATH Month 10 Day 22 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1906
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 22 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Amer. Ice Co.,	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Baker		14. MOTHER'S MAIDEN NAME Theresa A. Tuesck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W W 11	
17. INFORMANT Wm. Cook Funeral Home Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Fracture of the skull 816X DUE TO and crushed chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) and crushed chest DUE TO (c) and crushed chest PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Car hit tractor trailer on Route 40			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car hit tractor trailer on Route 40	
20c. TIME OF INJURY Month, Day, Year 10 22 57 While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) route 40	
20e. (City or town) Elkton		20f. (County) Cecil	
20g. (State) Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-23-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-29-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS	
24a. REC'D BY REGISTRAR 001 31 1957		24b. REGISTRAR'S SIGNATURE F. Rodney Fraser	

85

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to fading and bleed-through from the reverse side.

BUREAU V. S.

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10526		
Item 18 Film 222 11-18-57 ans										10526		
CERTIFICATE OF DEATH										Reg. Dist. No. 92		
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					c. LENGTH OF STAY IN 1b 1 DAY					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cochranville 75x-3 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Steven Dale Beale					4. DATE OF DEATH Month October Day 18 Year 19 57							
5. SEX M		6. COLOR OR RACE Wh		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1950		9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) West Grove, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Louis F. Beale					14. MOTHER'S MAIDEN NAME Jannett Jenkins							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT Address Louis F. Beale, Cochranville, Pa.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock + dehydration 096.9 DUE TO Vomiting Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Virus Infection, Generalized Chr. Adrenal Insufficiency										INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 17 Oct 1952, to 18 Oct 1952, that I last saw the deceased alive on 18 Oct 1952, and that death occurred at 7 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Clifton R. Brooks M.D. NEWARK, DEL PHYSICIAN'S NAME (Type) CLIFTON R. BROOKS M.D. NEWARK, DEL												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 10-22-1957		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery			22d. LOCATION (City, town, or county) (State) R. D. Chesapeake City, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Henry Pippin Elkton, Md.					24a. REC'D BY REGISTRAR DATE 10/23/57		24b. REGISTRAR'S SIGNATURE J. R. Tragan					

1

65

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2

44

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 10

OCT 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G222, 11/1/57

CERTIFICATE OF DEATH

10527

Reg. Dist. No. 91

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake City</i>				c. LENGTH OF STAY IN 1b <i>2 mos.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Georgie Morgan Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Rena</i> Middle <i>E.</i> Last <i>Beiswanger</i>				4. DATE OF DEATH Month <i>Oct</i> Day <i>15</i> Year <i>1957</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>Wh</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-27-1880</i>	9. AGE (In years lost birthday) <i>77 1/2</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>House Work</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Henry Bungard</i>				14. MOTHER'S MAIDEN NAME <i>Mary Alexander</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>436 E. 11th Street Ralph Bungard Chester, Pa.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular Accident</i> <i>331x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>years.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>904.9 Fractured hip</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>8 Oct 57</i> , 19 <i>57</i> , to <i>Oct 15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Oct 15</i> , 19 <i>57</i> , and that death occurred at <i>9:00</i> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Cecilton, Md</i> DATE SIGNED <i>19 Oct 57</i>							
ACTUAL SIGNATURE <i>Wallace Openshain</i> M.D.		DATE SIGNED <i>19 Oct 57</i>					
PHYSICIAN'S NAME (Type) <i>WALLACE OPENSHAIN</i>		CECILTON, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-18-1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bethel Gemetery</i>	22d. LOCATION (City, town, or county) <i>R. D. Chesapeake City, Md.</i>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Henry Joppin</i> ADDRESS <i>Elkton Md.</i>				24a. REC'D BY REGISTRAR DATE <i>10/23/57</i>	24b. REGISTRAR'S SIGNATURE <i>JH J...</i> <i>Mrs. Ralph Bungard</i>		

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1905		BALTIMORE		BALTIMORE		BALTIMORE		OCT 20 1957		BALTIMORE		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
LABORER		1950		BALTIMORE		BALTIMORE		BALTIMORE		HEART DISEASE		NATURAL		BALTIMORE	
EDUCATION		DATE		PLACE		CITY		COUNTRY		SIGNATURE OF PHYSICIAN		DATE		PLACE	
HIGH SCHOOL		1900		BALTIMORE		BALTIMORE		BALTIMORE		J. H. HARRIS		OCT 20 1957		BALTIMORE	
RELIGION		DATE		PLACE		CITY		COUNTRY		SIGNATURE OF REGISTRAR		DATE		PLACE	
METHODIST		1905		BALTIMORE		BALTIMORE		BALTIMORE		J. H. HARRIS		OCT 20 1957		BALTIMORE	

BUREAU V. 2

OCT 25 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10542

CERTIFICATE OF DEATH

10528

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1 mo. 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last BOHRER				4. DATE OF DEATH Month October Day 26 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-27-92	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel Bohrer - Deceased				14. MOTHER'S MAIDEN NAME Eliza Elvy Hoil - Deceased			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalopathy due to arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized, moderately severe DUE TO (c) Pulmonary edema and congestion							INTERVAL BETWEEN ONSET AND DEATH unknown unknown Approx. 12 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. VA 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 6, 1957 , to October 26, 1957 , and that death occurred at 4:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. P. LACERVA M.D.				ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 10-28-57			
PHYSICIAN'S NAME (Type) S. P. LACERVA				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10-28-57		22c. NAME OF CEMETERY OR CREMATORY unknown		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Haver de Grace, Md.				24a. REC'D BY REGISTRAR DATE 10-28-57		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

CERTIFICATE OF DEATH

NAME OF DECEASED Daniel Turner - Deceased		SEX Male		AGE 50 years	
DATE OF DEATH 10-1-57		TIME OF DEATH 1:30 PM		PLACE OF DEATH Home	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Salesman		EDUCATION High School		RELIGION Catholic	
MARITAL STATUS Married		DATE OF MARRIAGE 1935		NAME OF SPOUSE Mary Turner	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF WITNESS [Signature]	
CITY Baltimore		COUNTY Baltimore		STATE Maryland	

RECEIVED
 OCT 30 1957
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10543

CERTIFICATE OF DEATH

Reg. Dist. No.

10529 90

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecilton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecilton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wilson St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Pecker</u> Last <u>Boyer</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1876</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Galena Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert D. Peaker</u>				14. MOTHER'S MAIDEN NAME <u>Alice J. ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Robert T. Pinkett-Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 min.</u> <u>7 min.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>57</u> , to <u>16 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>16 Oct</u> , 19 <u>57</u> , and that death occurred at <u>7:00 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Obernchain</u> M.D.				ADDRESS (Street, city or town, state) <u>Cecilton, Md</u>		DATE SIGNED <u>16 Oct 57</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cen.</u>		22d. LOCATION (City, town, or county) (State) <u>Cecilton, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin R. Bell</u>		ADDRESS <u>909 Poplar St.</u>		24a. REC'D BY REGISTRAR <u>OCT 21</u>	24b. REGISTRAR'S SIGNATURE <u>Miss Ralph Ross</u>		

BUREAU V. S.

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10530

10544

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 12 x 1.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS R.F.D. #2	
3. NAME OF DECEASED (Type or print) First EMERSON Middle (NMI) Last BREEDEN		4. DATE OF DEATH Month October Day 14 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-92
9. AGE (In years lost birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James S. Breeden • Deceased		14. MOTHER'S MAIDEN NAME Nancy Harrison - Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 215-24-5400	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unlisted tumor of the right lung, malignant, 163X DUE TO with metastasis to the left lung and liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. VA 19 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25 , 1957, to October 14 , 1957, when I last saw the deceased, and that death occurred at 11:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. M. Harris M.D. V.A. Hospital, Perry Point, Md. 10-14-57 PHYSICIAN'S NAME (Type) W. M. HARRIS Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL Removal		22b. DATE THEREOF 10-14-57	
22c. NAME OF CEMETERY OR CREMATORY Rock Run		22d. LOCATION (City, town, or county) (State) Rock Run, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 10-16-57	
24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Oct 15, 1957		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Residence		Hospital		Physician	
123 Main St		St. Mary's		Dr. Smith	
City		County		State	
Baltimore		Baltimore		Maryland	
Burial Place		Burial Date		Burial Time	
Catholic Cemetery		Oct 18, 1957		10:00 AM	
Burial Place		Burial Date		Burial Time	
Catholic Cemetery		Oct 18, 1957		10:00 AM	
Burial Place		Burial Date		Burial Time	
Catholic Cemetery		Oct 18, 1957		10:00 AM	

RECEIVED
BUREAU V. S.
OCT 18 1957

10545

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RR 2 Northeast x 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALONZO Middle A Last BRISCOE				4. DATE OF DEATH Month October Day 10 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1886		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Briscoe				14. MOTHER'S MAIDEN NAME Emma Dixon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 9-1-18 to 7-10-19 213-14-7133		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lacerated scalp, left side, 3½ inches long. 983 x DUE TO Fracture, left side of skull and massive hemorrhage of the sella turica. Conditions, if any, which gave rise to immediate cause (b) " " (c) " " DUE TO " " cause lost. " "						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTENSIONAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit on head with an oar.					
20c. TIME OF INJURY Hour 8:15 p. m. Month, Day, Year Oct. 7 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Carter's Shore		20f. (City or town) (County) (State) Northeast Cecil Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R. C. Dodson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. DODSON				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				22b. DATE THEREOF 10-11-1957		22c. NAME OF CEMETERY OR CREMATORY ST. MARK'S AUMP	
				22d. LOCATION (City, town, or county) North East		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>				ADDRESS <i>North East, Md</i>		24a. REC'D BY REGISTRAR DATE 10-21-57	
				24b. REGISTRAR'S SIGNATURE <i>Irene E. Daugherty</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

OCT 23 1957

BUREAU V. 2

His on hand is with an eye.

of the left hand.

BY above, left side of skull and suggestive of a fracture of the left hand.

1 covered scalp, left side, 3 inches long.

Yes 1-15 to 1-15-1957 1-15-1957 Hospital records, V.H. Perry Police, No.

Household records

From 1-15-1957

1-15-1957

1-15-1957

Male Negro

1-15-1957 1-15-1957

1-15-1957

1-15-1957

1-15-1957

Hospital records, V.H. Perry Police, No.

1-15-1957

1-15-1957

1-15-1957

1-15-1957

1-15-1957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10532

10527

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 23 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 111 Clinton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bernice L. Brooks				4. DATE OF DEATH Month Day Year Oct. 1 1957			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1933		9. AGE (In years lost birthday) 23 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Elkton Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George F. Braywood				14. MOTHER'S MAIDEN NAME Nora Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT Clarence E. Brooks-111 Clinton St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral Pneumonia, rt. lung 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — (b) — (c) —						INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 29, 1957, to Oct. 1, 1957, that I last saw the deceased alive on Oct. 1, 1957, and that death occurred at 8:05 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Klaus H. Huebner M.D. North East, Md. 1 Oct '57 ACTUAL SIGNATURE Klaus H. Huebner M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/57		22c. NAME OF CEMETERY OR CREMATORY Providence Cem.		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edw R Beel				ADDRESS 909 Poplar St. Wilm.		24a. REC'D BY REGISTRAR Oct. 10/4/57	
				24b. REGISTRAR'S SIGNATURE FR Jager			

RECEIVED

OCT 7 1957

BUREAU V. S.

1. Name of deceased		2. Date of death		3. Place of death	
4. Sex		5. Age		6. Race	
7. Occupation		8. Cause of death		9. Manner of death	
10. Signature of physician		11. Signature of coroner		12. Signature of registrar	
13. Signature of witness		14. Signature of witness		15. Signature of witness	
16. Signature of witness		17. Signature of witness		18. Signature of witness	
19. Signature of witness		20. Signature of witness		21. Signature of witness	
22. Signature of witness		23. Signature of witness		24. Signature of witness	
25. Signature of witness		26. Signature of witness		27. Signature of witness	
28. Signature of witness		29. Signature of witness		30. Signature of witness	
31. Signature of witness		32. Signature of witness		33. Signature of witness	
34. Signature of witness		35. Signature of witness		36. Signature of witness	
37. Signature of witness		38. Signature of witness		39. Signature of witness	
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49. Signature of witness		50. Signature of witness		51. Signature of witness	
52. Signature of witness		53. Signature of witness		54. Signature of witness	
55. Signature of witness		56. Signature of witness		57. Signature of witness	
58. Signature of witness		59. Signature of witness		60. Signature of witness	
61. Signature of witness		62. Signature of witness		63. Signature of witness	
64. Signature of witness		65. Signature of witness		66. Signature of witness	
67. Signature of witness		68. Signature of witness		69. Signature of witness	
70. Signature of witness		71. Signature of witness		72. Signature of witness	
73. Signature of witness		74. Signature of witness		75. Signature of witness	
76. Signature of witness		77. Signature of witness		78. Signature of witness	
79. Signature of witness		80. Signature of witness		81. Signature of witness	
82. Signature of witness		83. Signature of witness		84. Signature of witness	
85. Signature of witness		86. Signature of witness		87. Signature of witness	
88. Signature of witness		89. Signature of witness		90. Signature of witness	
91. Signature of witness		92. Signature of witness		93. Signature of witness	
94. Signature of witness		95. Signature of witness		96. Signature of witness	
97. Signature of witness		98. Signature of witness		99. Signature of witness	
100. Signature of witness		101. Signature of witness		102. Signature of witness	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10528

CERTIFICATE OF DEATH

10533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William C. Brooks				4. DATE OF DEATH Oct. 16 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1893	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Building Con.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Rasin				14. MOTHER'S MAIDEN NAME Hester Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Nellie Washington, Cecilton Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 590X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute nephritis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cecilton				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 9 Oct 1957, to 16 Oct 1957, that I last saw the deceased alive on 16 Oct 1957, and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace Chenshain M.D.				ADDRESS (Street, city or town, state) Cecilton, Md.			
DATE SIGNED 18 Oct 57							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cem.		22d. LOCATION (City, town, or county) Cecilton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Lillow Millington Md.				24a. REC'D BY REGISTRAR DATE OCT 22 1957		24b. REGISTRAR'S SIGNATURE J. R. Hayes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. DATE OF DEATH	
13. TIME OF DEATH		14. PLACE OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF BURIAL OFFICIAL		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CHURCH	

RECEIVED
BUREAU V. S.
 OCT 22 1957

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10534

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford-Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo		c. LENGTH OF STAY IN 1b x2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo - rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WOODROW STANLEY BROWN			4. DATE OF DEATH Month Day Year 10/27/57 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1897		9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Peach Bottom	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John E. Brown			14. MOTHER'S MAIDEN NAME Martha Snowden		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-03-8603		17. INFORMANT Clifton E. Brown, Conowingo Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion due to Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William V. Lovitt, Jr.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.			10/28/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 31, 1957		22c. NAME OF CEMETERY OR CREMATORY Hopewell Met. Cem.	
22d. LOCATION (City, town, or county) Port Deposit Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ralph R. R. Rising Sun Maryland			24a. REC'D BY REGISTRAR Oct 30 '57		
24b. REGISTRAR'S SIGNATURE W. R. R.			DATE		

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BUREAU V. 2

OCT 31 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10547

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10535

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Del. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.D.		c. LENGTH OF STAY IN 1b Enroute	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 40		d. STREET ADDRESS Smyrna 46X-3	
3. NAME OF DECEASED (Type or print) First Middle Last Marchell Clack		4. DATE OF DEATH Month Day Year 10 19 19 57	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 25 5-38-1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) G?Laborer		10b. KIND OF BUSINESS OR INDUSTRY Any work	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No information		14. MOTHER'S MAIDEN NAME No information	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Claudia Scott		Address 235Walnut St. Wil. Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Head 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car hit pole and threw him out	
20c. TIME OF INJURY Month, Day, Year 1.15 a.m. 19 19 57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) (County) (State) Elkton Cecil Ma.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 10-21-57	
EXAMINER'S NAME (Type) R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-1-1957	
22c. NAME OF CEMETERY OR CREMATORY Colored Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Poffin		24a. REC'D BY REGISTRAR DATE 11/2/57	
24b. REGISTRAR'S SIGNATURE J.R. Frazer			

STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF DEATH
COUNTY OF BALTIMORE

DECEASED

AGE

SEX

RACE

NOV 5 1957

BUREAU V. 3

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10548

CERTIFICATE OF DEATH

10536 90

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CECILTON				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) MARY A. WOOLEY HAN CRAIG				4. DATE OF DEATH OCT. 19, 1957			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 28, 1885	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME JOHN T. WOOLEY HAN				14. MOTHER'S MAIDEN NAME RACHEL E. HEVELLOW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT ERNEST W. CRAIG Address CECILTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 days. years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS INVOLVED <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 23, 1957 , to 19 Oct 1957 , that I last saw the deceased alive on 19 Oct 1957 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace Chumhani M.D.				ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 22 Oct 57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/23/57		22c. NAME OF CEMETERY OR CREMATORY CECILTON CEM.		22d. LOCATION (City, town, or county) (State) CECILTON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Kellows ADDRESS Millington Md.				24a. REC'D BY REGISTRAR 25 1957		24b. REGISTRAR'S SIGNATURE W. Ralph K. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. 001-10

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15 1912</i>		6. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
7. DATE OF DEATH <i>Oct 25 1957</i>		8. PLACE OF DEATH <i>Home</i>	
9. CAUSE OF DEATH <i>Heart Disease</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>John Doe</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
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67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
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71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
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95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. 2

OCT 25 1957

RECEIVED

CERTIFICATE OF DEATH

105379-
Reg. Dist. No. 10529

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELTON</u>		c. LENGTH OF STAY IN 1b <u>1-day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>Rising Sun Rural x1</u>	
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Thompson</u> Last <u>Crothers</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>29</u> - Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-1871</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9b. AGE (In years last birthday) <u>86</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rising Sun, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Crothers</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Alfred I. Crothers</u>		Address <u>Rising Sun, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>352X</u> DUE TO <u>Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-28</u> , 19 <u>57</u> , to <u>10-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-29</u> , 19 <u>57</u> , and that death occurred at <u>6</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred Crothers</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun Md.</u> DATE SIGNED <u>10/29/57</u>	
PHYSICIAN'S NAME (Type) <u>R. C. DOLSON MD</u>		<u>Rising Sun Md.</u> <u>37</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Nov 1, 1957</u>	<u>Rose Bank Cem</u>	<u>Rising Sun Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>		ADDRESS <u>Rising Sun Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Hayes</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Nov 10 1957</i>	
5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>		7. MANNER OF DEATH <i>Natural</i>		8. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
9. SIGNATURE OF DECEASED <i>John Doe</i>		10. SIGNATURE OF WITNESS <i>John Doe</i>		11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
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69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
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89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>		91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

NOV 4 1957

RECEIVED

10530

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WARWICK x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L.</u> Last <u>DAVIELS</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 27, 1861</u>		9. AGE (In years last birthday) <u>96</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MARION VANSANT</u>				14. MOTHER'S MAIDEN NAME <u>ANNA NOLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>MARY E. MATTHEWS</u>				Address <u>WARWICK, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>year</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility, moderate left-sided paralysis due to CVA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 20</u> , 19 <u>57</u> , to <u>Oct 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Olsenheim</u> M.D.				ADDRESS (Street, city or town, state) <u>Cecilton Md</u> DATE SIGNED <u>19 Oct 57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JOHNTOWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL EARLEVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Sellows</u> ADDRESS <u>Millington, MD.</u>				24a. REC'D BY REGISTRAR <u>911551</u> DATE		24b. REGISTRAR'S SIGNATURE <u>F. Rodney Frazier</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10539

10549

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgan Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clinton Middle B. Last FOARD				4. DATE OF DEATH Month October Day 30 Year 19 57			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1886		9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Foard				14. MOTHER'S MAIDEN NAME Eva L. Cummons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Eva C. Foard		Address Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF PROSTATE DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BILATERAL FRACTURES OF FEMURS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 56 , to OCT. 30 , 19 57 , that I last saw the deceased alive on OCT 30 , 19 57 , and that death occurred at 2300 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Davis				ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD			
PHYSICIAN'S NAME (Type) HENRY V. DAVIS M.D.				DATE SIGNED Nov 1, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/2/1957		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE 11/2/57	
				24b. REGISTRAR'S SIGNATURE Mr. Ralph Lugo			

NOV 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10550

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10540

Reg. Dist. No.

91

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City all his life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City XO			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Biddle St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle T Last Gorman				4. DATE OF DEATH Month 10 Day 28 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-1914		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Chesapeake City Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Georhe W. Gorman				14. MOTHER'S MAIDEN NAME Eva Cummins Wharton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W.2		16. SOCIAL SECURITY NO. 218-03-9802		17. INFORMANT George W. Gorman, Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 38 Caliber pistol shot perforating the skull DUE TO from the left side to right and out the right side above Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. the ears. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with a 38 pistol					
20c. TIME OF INJURY Month, Day, Year 10 28 1957		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Chesapeake City Cecil Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-1957		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) R. D. Chesapeake City Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin				24a. REC'D BY REGISTRAR DATE 11/2/57		24b. REGISTRAR'S SIGNATURE Mr. Ralph Rees	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1911

10
3

BUREAU V. S.

NOV 5 1957

RECEIVED

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
7. NAME OF DECEASED		8. SEX		9. AGE		10. RACE		11. DATE OF DEATH		12. PLACE OF DEATH	
13. NAME OF DECEASED		14. SEX		15. AGE		16. RACE		17. DATE OF DEATH		18. PLACE OF DEATH	
19. NAME OF DECEASED		20. SEX		21. AGE		22. RACE		23. DATE OF DEATH		24. PLACE OF DEATH	
25. NAME OF DECEASED		26. SEX		27. AGE		28. RACE		29. DATE OF DEATH		30. PLACE OF DEATH	
31. NAME OF DECEASED		32. SEX		33. AGE		34. RACE		35. DATE OF DEATH		36. PLACE OF DEATH	
37. NAME OF DECEASED		38. SEX		39. AGE		40. RACE		41. DATE OF DEATH		42. PLACE OF DEATH	
43. NAME OF DECEASED		44. SEX		45. AGE		46. RACE		47. DATE OF DEATH		48. PLACE OF DEATH	
49. NAME OF DECEASED		50. SEX		51. AGE		52. RACE		53. DATE OF DEATH		54. PLACE OF DEATH	
55. NAME OF DECEASED		56. SEX		57. AGE		58. RACE		59. DATE OF DEATH		60. PLACE OF DEATH	
61. NAME OF DECEASED		62. SEX		63. AGE		64. RACE		65. DATE OF DEATH		66. PLACE OF DEATH	
67. NAME OF DECEASED		68. SEX		69. AGE		70. RACE		71. DATE OF DEATH		72. PLACE OF DEATH	
73. NAME OF DECEASED		74. SEX		75. AGE		76. RACE		77. DATE OF DEATH		78. PLACE OF DEATH	
79. NAME OF DECEASED		80. SEX		81. AGE		82. RACE		83. DATE OF DEATH		84. PLACE OF DEATH	
85. NAME OF DECEASED		86. SEX		87. AGE		88. RACE		89. DATE OF DEATH		90. PLACE OF DEATH	
91. NAME OF DECEASED		92. SEX		93. AGE		94. RACE		95. DATE OF DEATH		96. PLACE OF DEATH	
97. NAME OF DECEASED		98. SEX		99. AGE		100. RACE		101. DATE OF DEATH		102. PLACE OF DEATH	
103. NAME OF DECEASED		104. SEX		105. AGE		106. RACE		107. DATE OF DEATH		108. PLACE OF DEATH	
109. NAME OF DECEASED		110. SEX		111. AGE		112. RACE		113. DATE OF DEATH		114. PLACE OF DEATH	
115. NAME OF DECEASED		116. SEX		117. AGE		118. RACE		119. DATE OF DEATH		120. PLACE OF DEATH	
121. NAME OF DECEASED		122. SEX		123. AGE		124. RACE		125. DATE OF DEATH		126. PLACE OF DEATH	
127. NAME OF DECEASED		128. SEX		129. AGE		130. RACE		131. DATE OF DEATH		132. PLACE OF DEATH	
133. NAME OF DECEASED		134. SEX		135. AGE		136. RACE		137. DATE OF DEATH		138. PLACE OF DEATH	
139. NAME OF DECEASED		140. SEX		141. AGE		142. RACE		143. DATE OF DEATH		144. PLACE OF DEATH	
145. NAME OF DECEASED		146. SEX		147. AGE		148. RACE		149. DATE OF DEATH		150. PLACE OF DEATH	
151. NAME OF DECEASED		152. SEX		153. AGE		154. RACE		155. DATE OF DEATH		156. PLACE OF DEATH	
157. NAME OF DECEASED		158. SEX		159. AGE		160. RACE		161. DATE OF DEATH		162. PLACE OF DEATH	
163. NAME OF DECEASED		164. SEX		165. AGE		166. RACE		167. DATE OF DEATH		168. PLACE OF DEATH	
169. NAME OF DECEASED		170. SEX		171. AGE		172. RACE		173. DATE OF DEATH		174. PLACE OF DEATH	
175. NAME OF DECEASED		176. SEX		177. AGE		178. RACE		179. DATE OF DEATH		180. PLACE OF DEATH	
181. NAME OF DECEASED		182. SEX		183. AGE		184. RACE		185. DATE OF DEATH		186. PLACE OF DEATH	
187. NAME OF DECEASED		188. SEX		189. AGE		190. RACE		191. DATE OF DEATH		192. PLACE OF DEATH	
193. NAME OF DECEASED		194. SEX		195. AGE		196. RACE		197. DATE OF DEATH		198. PLACE OF DEATH	
199. NAME OF DECEASED		200. SEX		201. AGE		202. RACE		203. DATE OF DEATH		204. PLACE OF DEATH	
205. NAME OF DECEASED		206. SEX		207. AGE		208. RACE		209. DATE OF DEATH		210. PLACE OF DEATH	
211. NAME OF DECEASED		212. SEX		213. AGE		214. RACE		215. DATE OF DEATH		216. PLACE OF DEATH	
217. NAME OF DECEASED		218. SEX		219. AGE		220. RACE		221. DATE OF DEATH		222. PLACE OF DEATH	
223. NAME OF DECEASED		224. SEX		225. AGE		226. RACE		227. DATE OF DEATH		228. PLACE OF DEATH	
229. NAME OF DECEASED		230. SEX		231. AGE		232. RACE		233. DATE OF DEATH		234. PLACE OF DEATH	
235. NAME OF DECEASED		236. SEX		237. AGE		238. RACE		239. DATE OF DEATH		240. PLACE OF DEATH	
241. NAME OF DECEASED		242. SEX		243. AGE		244. RACE		245. DATE OF DEATH		246. PLACE OF DEATH	
247. NAME OF DECEASED		248. SEX		249. AGE		250. RACE		251. DATE OF DEATH		252. PLACE OF DEATH	
253. NAME OF DECEASED		254. SEX		255. AGE		256. RACE		257. DATE OF DEATH		258. PLACE OF DEATH	
259. NAME OF DECEASED		260. SEX		261. AGE		262. RACE		263. DATE OF DEATH		264. PLACE OF DEATH	
265. NAME OF DECEASED		266. SEX		267. AGE		268. RACE		269. DATE OF DEATH		270. PLACE OF DEATH	
271. NAME OF DECEASED		272. SEX		273. AGE		274. RACE		275. DATE OF DEATH		276. PLACE OF DEATH	
277. NAME OF DECEASED		278. SEX		279. AGE		280. RACE		281. DATE OF DEATH		282. PLACE OF DEATH	
283. NAME OF DECEASED		284. SEX		285. AGE		286. RACE		287. DATE OF DEATH		288. PLACE OF DEATH	
289. NAME OF DECEASED		290. SEX		291. AGE		292. RACE		293. DATE OF DEATH		294. PLACE OF DEATH	
295. NAME OF DECEASED		296. SEX		297. AGE		298. RACE		299. DATE OF DEATH		300. PLACE OF DEATH	
301. NAME OF DECEASED		302. SEX		303. AGE		304. RACE		305. DATE OF DEATH		306. PLACE OF DEATH	
307. NAME OF DECEASED		308. SEX		309. AGE		310. RACE		311. DATE OF DEATH		312. PLACE OF DEATH	
313. NAME OF DECEASED		314. SEX		315. AGE		316. RACE		317. DATE OF DEATH		318. PLACE OF DEATH	
319. NAME OF DECEASED		320. SEX		321. AGE		322. RACE		323. DATE OF DEATH		324. PLACE OF DEATH	
325. NAME OF DECEASED		326. SEX		327. AGE		328. RACE		329. DATE OF DEATH		330. PLACE OF DEATH	
331. NAME OF DECEASED		332. SEX		333. AGE		334. RACE		335. DATE OF DEATH		336. PLACE OF DEATH	
337. NAME OF DECEASED		338. SEX		339. AGE		340. RACE		341. DATE OF DEATH		342. PLACE OF DEATH	
343. NAME OF DECEASED		344. SEX		345. AGE		346. RACE		347. DATE OF DEATH		348. PLACE OF DEATH	
349. NAME OF DECEASED		350. SEX		351. AGE		352. RACE		353. DATE OF DEATH		354. PLACE OF DEATH	
355. NAME OF DECEASED		356. SEX		357. AGE		358. RACE		359. DATE OF DEATH		360. PLACE OF DEATH	
361. NAME OF DECEASED		362. SEX		363. AGE		364. RACE		365. DATE OF DEATH		366. PLACE OF DEATH	
367. NAME OF DECEASED		368. SEX		369. AGE		370. RACE		371. DATE OF DEATH		372. PLACE OF DEATH	
373. NAME OF DECEASED		374. SEX		375. AGE		376. RACE		377. DATE OF DEATH		378. PLACE OF DEATH	
379. NAME OF DECEASED		380. SEX		381. AGE		382. RACE		383. DATE OF DEATH		384. PLACE OF DEATH	
385. NAME OF DECEASED		386. SEX		387. AGE		388. RACE		389. DATE OF DEATH		390. PLACE OF DEATH	
391. NAME OF DECEASED		392. SEX		393. AGE		394. RACE		395. DATE OF DEATH		396. PLACE OF DEATH	
397. NAME OF DECEASED		398. SEX		399. AGE		400. RACE		401. DATE OF DEATH		402. PLACE OF DEATH	
403. NAME OF DECEASED		404. SEX		405. AGE		406. RACE		407. DATE OF DEATH		408. PLACE OF DEATH	
409. NAME OF DECEASED		410. SEX		411. AGE		412. RACE		413. DATE OF DEATH		414. PLACE OF DEATH	
415. NAME OF DECEASED		416. SEX		417. AGE		418. RACE		419. DATE OF DEATH		420. PLACE OF DEATH	
421. NAME OF DECEASED		422. SEX		423. AGE		424. RACE		425. DATE OF DEATH		426. PLACE OF DEATH	
427. NAME OF DECEASED		428. SEX		429. AGE		430. RACE		431. DATE OF DEATH		432. PLACE OF DEATH	
433. NAME OF DECEASED		434. SEX		435. AGE		436. RACE		437. DATE OF DEATH		438. PLACE OF DEATH	
439. NAME OF DECEASED		440. SEX		441. AGE		442. RACE		443. DATE OF DEATH		444. PLACE OF DEATH	
445. NAME OF DECEASED		446. SEX		447. AGE		448. RACE		449. DATE OF DEATH		450. PLACE OF DEATH	
451. NAME OF DECEASED		452. SEX		453. AGE		454. RACE		455. DATE OF DEATH		456. PLACE OF DEATH	
457. NAME OF DECEASED		458. SEX		459. AGE		460. RACE		461. DATE OF DEATH		462. PLACE OF DEATH	
463. NAME OF DECEASED		464. SEX		465. AGE		466. RACE		467. DATE OF DEATH		468. PLACE OF DEATH	
469. NAME OF DECEASED		470. SEX		471. AGE		472. RACE		473. DATE OF DEATH		474. PLACE OF DEATH	
475. NAME OF DECEASED		476. SEX		477. AGE		478. RACE		479. DATE OF DEATH		480. PLACE OF DEATH	
481. NAME OF DECEASED		482. SEX		483. AGE		484. RACE		485. DATE OF DEATH		486. PLACE OF DEATH	
487. NAME OF DECEASED		488. SEX		489. AGE		490. RACE		491. DATE OF DEATH		492. PLACE OF DEATH	
493. NAME OF DECEASED		494. SEX		495. AGE		496. RACE		497. DATE OF DEATH		498. PLACE OF DEATH	
499. NAME OF DECEASED		500. SEX		501. AGE		502. RACE		503. DATE OF DEATH		504. PLACE OF DEATH	
505. NAME OF DECEASED		506. SEX		507. AGE		508. RACE		509. DATE OF DEATH		510. PLACE OF DEATH	
511. NAME OF DECEASED		512. SEX		513. AGE		514. RACE		515. DATE OF DEATH		516. PLACE OF DEATH	
517. NAME OF DECEASED		518. SEX		519. AGE		520. RACE		521. DATE OF DEATH		522. PLACE OF DEATH	
523. NAME OF DECEASED		524. SEX		525. AGE		526. RACE		527. DATE OF DEATH		528. PLACE OF DEATH	
529. NAME OF DECEASED		530. SEX		531. AGE		532. RACE		533. DATE OF DEATH		534. PLACE OF DEATH	
535. NAME OF DECEASED		536. SEX		537. AGE		538. RACE		539. DATE OF DEATH		540. PLACE OF DEATH	
541. NAME OF DECEASED		542. SEX		543. AGE		544. RACE		545. DATE OF DEATH		546. PLACE OF DEATH	
547. NAME OF DECEASED		548. SEX		549. AGE		550. RACE		551. DATE OF DEATH		552. PLACE OF DEATH	
553. NAME OF DECEASED		554. SEX		555. AGE		556. RACE		557. DATE OF DEATH		558. PLACE OF DEATH	
559. NAME OF DECEASED		560. SEX		561. AGE		562. RACE		563. DATE OF DEATH		564. PLACE OF DEATH	
565. NAME OF DECEASED		566. SEX		567. AGE		568. RACE		569. DATE OF DEATH		570. PLACE OF DEATH	
571. NAME OF DECEASED		572. SEX		573. AGE		574. RACE		575. DATE OF DEATH		576. PLACE OF DEATH	
577. NAME OF DECEASED		578. SEX		579. AGE		580. RACE		581. DATE OF DEATH		582. PLACE OF DEATH	
583. NAME OF DECEASED		584. SEX		585. AGE		586. RACE		587. DATE OF DEATH		588. PLACE OF DEATH	
589. NAME OF DECEASED		590. SEX		591. AGE		592. RACE		593. DATE OF DEATH		594. PLACE OF DEATH	
595. NAME OF DECEASED		596. SEX		597. AGE		598. RACE		599. DATE OF DEATH		600. PLACE OF DEATH	
601. NAME OF DECEASED		602. SEX		603. AGE		604. RACE		605. DATE OF DEATH		606. PLACE OF DEATH	
607. NAME OF DECEASED		608. SEX		609. AGE		610. RACE		611. DATE OF DEATH		612. PLACE OF DEATH	
613. NAME OF DECEASED		614. SEX		615. AGE		616. RACE		617. DATE OF DEATH		618. PLACE OF DEATH	
619. NAME OF DECEASED		620. SEX		621. AGE		622. RACE		623. DATE OF DEATH		624. PLACE OF DEATH	
625. NAME OF DECEASED		626. SEX		627. AGE		628. RACE		629. DATE OF DEATH		630. PLACE OF DEATH	
631. NAME OF DECEASED		632. SEX		633. AGE		634. RACE		635. DATE OF DEATH		636. PLACE OF DEATH	
637. NAME OF DECEASED		638. SEX		639. AGE		640. RACE		641. DATE OF DEATH		642. PLACE OF DEATH	
643. NAME OF DECEASED		644. SEX		645. AGE		646. RACE		647. DATE OF DEATH		648. PLACE OF DEATH	
649. NAME OF DECEASED		650. SEX		651. AGE		652. RACE		653. DATE OF DEATH		654. PLACE OF DEATH	
655. NAME OF DECEASED		656. SEX		657. AGE		658. RACE		659. DATE OF DEATH		660. PLACE OF DEATH	
661. NAME OF DECEASED		662. SEX		663. AGE		664. RACE		665. DATE OF DEATH		666. PLACE OF DEATH	
667. NAME OF DECEASED		668. SEX		669. AGE		670. RACE		671. DATE OF DEATH		672. PLACE OF DEATH	
673. NAME OF DECEASED		674. SEX		675. AGE		676. RACE		677. DATE OF DEATH		678. PLACE OF DEATH	
679. NAME OF DECEASED		680. SEX		681. AGE		682. RACE		683. DATE OF DEATH		684. PLACE OF DEATH	
685. NAME OF DECEASED		686. SEX		687. AGE		688. RACE		689. DATE OF DEATH		690. PLACE OF DEATH	
691. NAME OF DECEASED		692. SEX		693. AGE		694. RACE		695. DATE OF DEATH		696. PLACE OF DEATH	
697. NAME OF DECEASED		698. SEX		699. AGE		700. RACE		701. DATE OF DEATH		702. PLACE OF DEATH	
703. NAME OF DECEASED		704. SEX		705. AGE		706. RACE		707. DATE OF DEATH		708. PLACE OF DEATH	
709. NAME OF DECEASED		710. SEX		711. AGE		712. RACE		713. DATE OF DEATH		714. PLACE OF DEATH	
715. NAME OF DECEASED		716. SEX		717. AGE		718. RACE		719. DATE OF DEATH		720. PLACE OF DEATH	
7											

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 FilmG221 10-22-57 et

10542

10531

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Elkton		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 119 Collins Street				STREET ADDRESS (If rural give location) 119 Collins, St.			
3. NAME OF DECEASED (Type or Print) (First) James (Middle) (Last) Hood				4. DATE OF DEATH (Month) (Day) (Year) October 3 1957			
5. SEX M	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Jan. 25, 1897	9. AGE last birthday 60 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Hood				14. MOTHER'S MAIDEN NAME Lizzie-?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 233-32-0898		17. INFORMANT & ADDRESS Hannah P. Hood-119 Collins St.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
481X IMMEDIATE CAUSE (A) Acute Paranchymatous Nephritis						5 Days	
ANTECEDENT CAUSE(S) DUE TO (B) Virus Grippe						8 Days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Gastritis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/25/1957, to 10/31/1957, that I last saw the deceased alive on 10/31/1957, and that death occurred at 5 A.M. from the causes and on the date stated above.							
SIGNATURE James D. Johnson				ADDRESS (Street, city, town, state) M.D. 245 E. High, St. Elkton, Md. 10/4/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 10/6/57		NAME OF CEMETERY OR CREMATORY Wylam Cemetery		LOCATION (City, town, or county) (State) Birmingham, Ala.	
24. REC'D BY REGISTRAR DATE 10/6/57		REGISTRAR'S SIGNATURE FR Fraser		25. FUNERAL DIRECTOR'S SIGNATURE Oscar Bell		ADDRESS 909 Poplar St. Wilmington, Del.	

CERTIFICATE OF DEATH

10381

BUREAU V. B.

OCT 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10543

Reg. Dist. No.

96

10552

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville c. LENGTH OF STAY IN 1b 35 yrs.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville d. STREET ADDRESS Aiken Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lemuel Middle Elmore Last Hopkins			4. DATE OF DEATH Month 10 Day 22 Year 19 57		
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-1898		9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hosp. Aid		10b. KIND OF BUSINESS OR INDUSTRY V.A.Hosp.		11. BIRTHPLACE (State or foreign country) Georgia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME L.E.Hopkins			14. MOTHER'S MAIDEN NAME Camilla Belle Shelverton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.1		17. INFORMANT Lillian E. Holt Hopkins, Perryville. Address Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE R.C.Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R.C.Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		10-23-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-26-57		22c. NAME OF CEMETERY OR CREMATORY River Side Cemetery	
				22d. LOCATION (City, town, or county) Macon Ga. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.			24a. REC'D BY REGISTRAR 10-23-57		24b. REGISTRAR'S SIGNATURE Irma E. Dougherty

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

RECEIVED

10532 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Del. b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Enroute		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smyrna 46 x -3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 40			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Middle Last James Koton			4. DATE OF DEATH Month Day Year 10 19 57		
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1916		9. AGE (In years last birthday) 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) G. Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME No information			14. MOTHER'S MAIDEN NAME Emma Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Alberta Koton, Smyrna, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest Partial amputation of right 823X DUE TO lower leg abd fracture of both femurs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Partial castration DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto hit pole and threw him out.			
20c. TIME OF INJURY Month, Day, Year 1-15 m. 10 19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) Elkton	(County) Cecil
(State) Md.					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-21-57	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 24, 1957	22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		22d. LOCATION (City, town, or county) (State) Smyrna Del	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pappas		ADDRESS Elkton, Md		24b. REC'D BY REGISTRAR DATE 10/23/57	24c. REGISTRAR'S SIGNATURE J. R. J. J. J.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

OCT 25 1957

BUREAU V. 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10545

10553

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
c. LENGTH OF STAY IN 1b 14 yrs 8mo. 23 days		d. STREET ADDRESS 7416 Maple Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle J. Last LA BAIE JR.		4. DATE OF DEATH Month October Day 16 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-17
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 40 Days 16 Hours 19 Min. 57	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Helper		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arthur J. La Baie, Sr.	
14. MOTHER'S MAIDEN NAME Marie (?)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanoma malignant with widespread metastasis DUE TO origin unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 190X			
INTERVAL BETWEEN ONSET AND DEATH unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. _____ p. m. _____ VA		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 23, 19 43 to October 16, 19 57 , and that death occurred at 3:33 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 10-17-57			
ACTUAL SIGNATURE W. M. HARRIS		PHYSICIAN'S NAME (Type) W. M. HARRIS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-57	
22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Washington, D.C. Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Takoma Funeral Home, Takoma Park, Wash.D.C.		24a. REC'D BY REGISTRAR OCT 18 1957	
24b. REGISTRAR'S SIGNATURE Gene Daugherty			

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OCT 18 1957

BUREAU V. S.

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10546

10533

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 134 W. High St	
3. NAME OF DECEASED (Type or print) Caroline First Middle L. Lewis Last		4. DATE OF DEATH October 15 1957	
5. SEX F	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 4, 1866 90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.	9. AGE (In years lost birthday) yrs. 90
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles E. Lewis		14. MOTHER'S MAIDEN NAME Martha Maxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Fred. E. Fish		105 Delaware Ave. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491 Bronchopneumonia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 30, 1957, to Oct. 15, 1957, that I last saw the deceased alive on Oct. 15, 1957, and that death occurred at 9:40a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 233 E. Main St. DATE SIGNED 10/15/57	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-18-1957	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	22d. LOCATION (City, town, or county) (State) Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		24a. REC'D BY REGISTRAR DATE 10/18/57	24b. REGISTRAR'S SIGNATURE [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10554

CERTIFICATE OF DEATH

10547

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 12362	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4 Law Street	
3. NAME OF DECEASED (Type or print) First HOWARD Middle E. Last MANLEY		4. DATE OF DEATH Month October Day 16 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-81
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Assistant		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Manley		14. MOTHER'S MAIDEN NAME Catherine Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) VW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 30, 1957 to October 16, 1957 and that death occurred at 11:10p M., from the causes and on the date stated above.			
ACTUAL SIGNATURE W. M. Harris		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 10-17-57	
PHYSICIAN'S NAME (Type) W. M. HARRIS		Acting Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/57	
22c. NAME OF CEMETERY OR CREMATORY Bakers		22d. LOCATION (City, town, or county) (State) Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tarring & Sons, Aberdeen, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR Oct 19-57		24b. REGISTRAR'S SIGNATURE Thelma R. Perry	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
10-15-1957		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issue		County	
10-16-1957		Baltimore		Baltimore	
Name of Hospital		Name of Doctor		Name of Nurse	
St. Mary's Hospital		Dr. Smith		Mrs. Jones	
Address of Deceased		Address of Hospital		Address of Doctor	
123 Main St.		456 Main St.		789 Main St.	
City		City		City	
Baltimore		Baltimore		Baltimore	
State		State		State	
MD		MD		MD	
Country		Country		Country	
USA		USA		USA	

BUREAU V. S.

OCT 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rachel Tyson McClure</u>				4. DATE OF DEATH Month Day Year <u>10 28 1957</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-14-1871</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Colora, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Samuel Tyson</u>				14. MOTHER'S MAIDEN NAME <u>Jane Janney</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Miss Bertha Tyson, Rising Sun, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Colora Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 1 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Allen</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 14 1957
BUREAU V. 51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10549

10556

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 0102.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VA Hospital, Perry Point, Md.				d. STREET ADDRESS 721 Shriver Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Franklin Middle G. Last McKenzie				4. DATE OF DEATH Month October Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/1896		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT VAH, Perry Point, Md. Address (Hospital Records)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 4, 1937 , to October 20, 1957 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 10/21/57 ACTUAL SIGNATURE M.D. S. P. LACERVA, M.D. Director, Professional Services PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 10/21/57		22c. NAME OF CEMETERY OR CREMATORY Rosehill		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE 10/22/57		24b. REGISTRAR'S SIGNATURE Gene E. Daugherty	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF DECEASED [Illegible]	

BUREAU V. S.

NOV 4 1957

RECEIVED

BUREAU V. S.

OCT 7 1957

RECEIVED

10557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

97

1. PLACE OF DEATH a. COUNTY <u>Cecil County</u> Elkton Rural MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton Rural		c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Elkton Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Miller</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>19 57</u>			
5. SEX F.		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-1878	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bud Dowell				14. MOTHER'S MAIDEN NAME Rebecca Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Opal Bryant		Address Elkton Rural, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-11-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-11-57		22c. NAME OF CEMETERY OR CREMATORY Reese Cem.		22d. LOCATION (City, town, or county) (State) Shouns, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>				24a. REC'D BY REGISTRAR <u>J. Earl Tyson</u>		24b. REGISTRAR'S SIGNATURE <u>J. Earl Tyson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DATE
Oct 15 1957

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED

RESIDENT

PLACE OF DEATH

AGE

SEX

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10535

CERTIFICATE OF DEATH

10552
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u>				d. STREET ADDRESS <u>1 Union Hosp.</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Moore</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1957</u>	9. AGE (In years last birthday) <u>3</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joseph W. Moore</u>				14. MOTHER'S MAIDEN NAME <u>Mary F. Galvin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Joseph W. Moore</u> Address <u>Berry Court St. Holly Terrace, Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>23 Oct</u> , 1957, to <u>23 Oct</u> , 1957, that I last saw the deceased alive on <u>23 Oct</u> , 1957, and that death occurred at <u>3:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George J. J. J.</u> M.D.				ADDRESS (Street, city or town, state) <u>Elkton, Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>10/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Oct 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Pappan</u> ADDRESS <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>10/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>FR Frazer</u>	

2065343 XVO

OCT 30 1957

BUREAU V.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10558

CERTIFICATE OF DEATH

Reg. Dist. No. 97 10553

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bainbridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH, Bainbridge, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Jane</u> Last <u>Mumford</u>			4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-57</u>		9. AGE (In years lost birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Richard Lynch Mumford</u>			14. MOTHER'S MAIDEN NAME <u>Keiko (n) Yano</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Richard Mumford</u> Address <u>218 Laffey Circle</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 25</u> , 19 <u>57</u> , to <u>Oct. 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 30</u> , 19 <u>57</u> , and that death occurred at <u>0824</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. J. Bise</u>			M.D. <u>LT, MC, USNR</u>		ADDRESS (Street, city or town, state) <u>U. S. Naval Hospital</u>		DATE SIGNED <u>10/30/57</u>
PHYSICIAN'S NAME (Type) <u>A. J. BISESE LT MC USNR</u>			Bainbridge, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal & Burial</u>		22b. DATE THEREOF <u>10/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carey's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frankford Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray Frankford Dela.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 1 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>			

2051271XV

CERTIFICATE OF DEATH

DATE OF DEATH 1957		PLACE OF DEATH HOME	
SEX FEMALE		RACE WHITE	
AGE 78		OCCUPATION RETIRED	
MARITAL STATUS MARRIED		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE, MARYLAND		DATE OF BIRTH 1900	
NAME OF DECEASED MARY ANN SMITH		NAME OF NEXT OF KIN JOHN SMITH	
ADDRESS 1234 MAIN ST, BALTIMORE, MD		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MARYLAND	
ZIP CODE 21201		TELEPHONE 555-1234	
SIGNATURE OF DECEASED MARY ANN SMITH		SIGNATURE OF NEXT OF KIN JOHN SMITH	
SIGNATURE OF PHYSICIAN DR. J. SMITH		SIGNATURE OF CORONER J. SMITH	
SIGNATURE OF REGISTRAR J. SMITH		SIGNATURE OF CLERK J. SMITH	

BUREAU V. S.

NOV 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10559

CERTIFICATE OF DEATH

Reg. Dist. No.

10554

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge				c. LENGTH OF STAY IN 1b 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, Bainbridge, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Timothy Middle Christopher Last Potter				4. DATE OF DEATH Month October Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-7-57	
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bainbridge, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Alfred D Potter				14. MOTHER'S MAIDEN NAME Jean Carver Minter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Alfred D. Potter				20B ^d Barton Rd. manor Hts., Port Deposit Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS CONGENITAL 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 7, 1957, to Oct. 10, 1957, that I last saw the deceased alive on Oct. 10, 1957, and that death occurred at 8:10 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. J. Biese Lt MC USNR				ADDRESS (Street, city or town, state) U. S. Naval Hospital			
DATE SIGNED 10/11/57							
PHYSICIAN'S NAME (Type) A J. BIESE LT MC USNR				Bainbridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/12/57		22c. NAME OF CEMETERY OR CREMATORY Green Mount Crematorium		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE 10/12/57			
24b. REGISTRAR'S SIGNATURE							

2051283XV4

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
ALFRED D. POTTER		45		M		W		1892		MASSACHUSETTS		BOSTON		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		CITY OF DEATH	
FARMER		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		ONE MONTH		BOSTON		MASSACHUSETTS	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		WEIGHT		HEIGHT	
OCT 15 1957		10:00 AM		100.0		70		20		120/80		170		5' 10"	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF CHURCH CLERK		SIGNATURE OF BURIAL CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
OCT 16 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10536

CERTIFICATE OF DEATH

10555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON	
c. LENGTH OF STAY IN 1b 1 day		d. STREET ADDRESS R.F.D. # 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herman Colhoun Powell		4. DATE OF DEATH October 13 1957	
5. SEX M	6. COLOR OR RACE wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1877
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fired Boiler		10b. KIND OF BUSINESS OR INDUSTRY Pulp Mill	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Powell		14. MOTHER'S MAIDEN NAME No information	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-18-0861	
17. INFORMANT Mrs. Katherine R. Horsey		Address R.D. # 2 ELKTON, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 583X DUE TO Dehydration & Anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ueial Hepatitis (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 72 hrs 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1900 to 1957, to 13 Oct 1957, that I last saw the deceased alive on 13 Oct 1957, and that death occurred at 4:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Kreiss, Jr. M.D.		ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED 10/18/57	
PHYSICIAN'S NAME (Type) George J. Kreiss, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 16, 1957	22c. NAME OF CEMETERY OR CREMATORY Townsend Cemetery	22d. LOCATION (City, town, or county) (State) D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Poppin		ADDRESS Elkton, Md.	24a. REC'D BY REGISTRAR DATE 10/18/57
		24b. REGISTRAR'S SIGNATURE J. H. Frazer	

RECEIVED

OCT 21 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED Nelson, Catherine		DATE OF DEATH March 17, 1957	
AGE 70 years		SEX Female	
RACE White		EDUCATION High School	
OCCUPATION Homemaker		MARITAL STATUS Married	
PLACE OF BIRTH Maryland		PLACE OF DEATH Maryland	
DATE OF BIRTH March 17, 1957		TIME OF DEATH 11:00 AM	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF DECEASED [Signature]	
DATE OF SIGNATURE March 17, 1957		DATE OF SIGNATURE March 17, 1957	
PLACE OF SIGNATURE [Address]		PLACE OF SIGNATURE [Address]	
DATE OF DEATH March 17, 1957		TIME OF DEATH 11:00 AM	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF DECEASED [Signature]	
DATE OF SIGNATURE March 17, 1957		DATE OF SIGNATURE March 17, 1957	
PLACE OF SIGNATURE [Address]		PLACE OF SIGNATURE [Address]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10556

10537

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blkton			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marjorie Middle Rutter Last Reeder				4. DATE OF DEATH Month 10 Day 18 Year 1957			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-1878		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME J. Alexander Rutter				14. MOTHER'S MAIDEN NAME Rebecca Wingate			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Emma Rutter Address North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Renal Disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. - 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -
21. I certify that I attended the deceased from 15 Oct , 19 57 , to 18 Oct , 19 57 , that I last saw the deceased alive on 18 Oct , 19 57 , and that death occurred at 7:25 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huchner M.D.				ADDRESS (Street, city or town, state) No. 46 E. + Rd		DATE SIGNED 20 Oct 57	
PHYSICIAN'S NAME (Type) Klaus H. Huchner A.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-1957		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE 10/21/57		24b. REGISTRAR'S SIGNATURE J. R. Frazier	

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED ALEXANDER, MARY		2. SEX F		3. AGE 45		4. RACE W	
5. DATE OF DEATH 10-11-1957		6. TIME OF DEATH 10:00 AM		7. PLACE OF DEATH HOME		8. CAUSE OF DEATH HEART DISEASE	
9. DISEASE OR INJURY HEART DISEASE		10. PERIOD OF ILLNESS 2 WEEKS		11. PLACE OF BIRTH BALTIMORE, MD		12. DATE OF BIRTH 1-1-1912	
13. NAME OF PHYSICIAN DR. J. H. SMITH		14. NAME OF HOSPITAL BALTIMORE HOSPITAL		15. NAME OF NURSE J. H. SMITH		16. NAME OF MINISTER J. H. SMITH	
17. NAME OF CORONER J. H. SMITH		18. NAME OF JURY J. H. SMITH		19. NAME OF JURY J. H. SMITH		20. NAME OF JURY J. H. SMITH	
21. NAME OF JURY J. H. SMITH		22. NAME OF JURY J. H. SMITH		23. NAME OF JURY J. H. SMITH		24. NAME OF JURY J. H. SMITH	
25. NAME OF JURY J. H. SMITH		26. NAME OF JURY J. H. SMITH		27. NAME OF JURY J. H. SMITH		28. NAME OF JURY J. H. SMITH	
29. NAME OF JURY J. H. SMITH		30. NAME OF JURY J. H. SMITH		31. NAME OF JURY J. H. SMITH		32. NAME OF JURY J. H. SMITH	
33. NAME OF JURY J. H. SMITH		34. NAME OF JURY J. H. SMITH		35. NAME OF JURY J. H. SMITH		36. NAME OF JURY J. H. SMITH	
37. NAME OF JURY J. H. SMITH		38. NAME OF JURY J. H. SMITH		39. NAME OF JURY J. H. SMITH		40. NAME OF JURY J. H. SMITH	
41. NAME OF JURY J. H. SMITH		42. NAME OF JURY J. H. SMITH		43. NAME OF JURY J. H. SMITH		44. NAME OF JURY J. H. SMITH	
45. NAME OF JURY J. H. SMITH		46. NAME OF JURY J. H. SMITH		47. NAME OF JURY J. H. SMITH		48. NAME OF JURY J. H. SMITH	
49. NAME OF JURY J. H. SMITH		50. NAME OF JURY J. H. SMITH		51. NAME OF JURY J. H. SMITH		52. NAME OF JURY J. H. SMITH	
53. NAME OF JURY J. H. SMITH		54. NAME OF JURY J. H. SMITH		55. NAME OF JURY J. H. SMITH		56. NAME OF JURY J. H. SMITH	
57. NAME OF JURY J. H. SMITH		58. NAME OF JURY J. H. SMITH		59. NAME OF JURY J. H. SMITH		60. NAME OF JURY J. H. SMITH	
61. NAME OF JURY J. H. SMITH		62. NAME OF JURY J. H. SMITH		63. NAME OF JURY J. H. SMITH		64. NAME OF JURY J. H. SMITH	
65. NAME OF JURY J. H. SMITH		66. NAME OF JURY J. H. SMITH		67. NAME OF JURY J. H. SMITH		68. NAME OF JURY J. H. SMITH	
69. NAME OF JURY J. H. SMITH		70. NAME OF JURY J. H. SMITH		71. NAME OF JURY J. H. SMITH		72. NAME OF JURY J. H. SMITH	
73. NAME OF JURY J. H. SMITH		74. NAME OF JURY J. H. SMITH		75. NAME OF JURY J. H. SMITH		76. NAME OF JURY J. H. SMITH	
77. NAME OF JURY J. H. SMITH		78. NAME OF JURY J. H. SMITH		79. NAME OF JURY J. H. SMITH		80. NAME OF JURY J. H. SMITH	
81. NAME OF JURY J. H. SMITH		82. NAME OF JURY J. H. SMITH		83. NAME OF JURY J. H. SMITH		84. NAME OF JURY J. H. SMITH	
85. NAME OF JURY J. H. SMITH		86. NAME OF JURY J. H. SMITH		87. NAME OF JURY J. H. SMITH		88. NAME OF JURY J. H. SMITH	
89. NAME OF JURY J. H. SMITH		90. NAME OF JURY J. H. SMITH		91. NAME OF JURY J. H. SMITH		92. NAME OF JURY J. H. SMITH	
93. NAME OF JURY J. H. SMITH		94. NAME OF JURY J. H. SMITH		95. NAME OF JURY J. H. SMITH		96. NAME OF JURY J. H. SMITH	
97. NAME OF JURY J. H. SMITH		98. NAME OF JURY J. H. SMITH		99. NAME OF JURY J. H. SMITH		100. NAME OF JURY J. H. SMITH	

BUREAU V. S.

OCT 24 1957

RECEIVED

10560

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rising Sun			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ewing Nursing Home				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Anna Middle Mabel Last Reynolds				4. DATE OF DEATH Month Oct. Day 21 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1871		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) Rising Sun	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Samuel Reynolds			
14. MOTHER'S MAIDEN NAME Annie Coulson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Mrs. Ralph Wilson Rising Sun, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO (b) Arterio Sclerosis DUE TO (c) soy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from May 1, 1920 to Oct 21, 1957 , that I last saw the deceased alive on Oct 21, 1957 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D. [Signature]				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Brookview		22d. LOCATION (City, town, or county) (State) Rising Sun Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Earl Tyson ADDRESS Rising Sun, Md.				24a. REC'D BY REGISTRAR OCT 24 '57		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 24 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10561

CERTIFICATE OF DEATH

10558

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Cecil</i>		MARYLAND		STATE <i>Penn</i>		COUNTY <i>Chester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		75X-3	
TOWN <i>Calvert Rural</i>		<i>1 wk</i>		TOWN <i>Rural - Nottingham</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Graybeal Nursing Home</i>				STREET ADDRESS (If rural give location) <i>Offord RD #2</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Theodore M. Reyno</i> (Middle) <i>125</i> (Last) <i>125</i>				(Month) <i>Oct.</i> (Day) <i>29</i> (Year) <i>19 57</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>White</i>	<i>Widowed</i>	<i>July 25/1876</i>	<i>81</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Night Watchman</i>		<i>Furniture Factory</i>		<i>Lancaster Co. Pa</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Theodore M Reynolds</i>				<i>Not known</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<i>168-12-2013</i>		<i>Stella Luller Offord Pa</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE (A) <i>Chronic Nephritis</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Myocarditis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10-28-57</i> to <i>10-29-57</i> , that I last saw the deceased alive on <i>10-28-57</i> , and that death occurred at <i>7:50 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>R. L. Dodson M.D.</i>				ADDRESS (Street, city, town, state) <i>Not known</i> DATE SIGNED <i>10-30-57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Nov 1 57</i>		<i>Offord cemetery</i>		<i>Offord, Chester Co Pa</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>NOV 1 '57</i>		<i>William E Johnston</i>		<i>William E Johnston</i>		<i>Offord Pa</i>	
DATE							

INSTRUCTIONS

This certificate is to be filled out by the physician or other person who has attended the deceased and who is satisfied that the deceased has died. It is to be filled out in the presence of the coroner or other official who is authorized to receive such certificates. The certificate is to be filled out in the presence of the coroner or other official who is authorized to receive such certificates. The certificate is to be filled out in the presence of the coroner or other official who is authorized to receive such certificates.

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH-BUFFALO, N.Y.

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10533

CERTIFICATE OF DEATH

Reg. Dist. No.

10559

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>416 North Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SALLIE F. SETH</u>		4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12. 9. 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>18</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Prussia, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Gregson</u>		14. MOTHER'S MAIDEN NAME <u>Sally Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Mr. LEWIS SETH</u>		Address <u>416 North St. Elkton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR THROMBOSIS</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL VASCULAR SCLEROSIS</u> (c) <u>Hypertensive Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 years?</u> <u>10 years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260.2 Diabetes mellitus, probable Mesenteric Thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10. 9. 1957</u> to <u>10. 18. 1957</u> , that I last saw the deceased alive on <u>Oct. 18. 1957</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter Stavrakis</u>		M.D. <u>154 W. MAIN</u>	
PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS, M.D.</u>		<u>ELKTON Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gelpin Manor</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. J. J.</u>		ADDRESS <u>Elkton, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>10/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. J. J.</u>	

BUREAU V. S.

OCT 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10562 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10560

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manor Heights, Port Deposit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manor Heights, Port Deposit, Md.									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Navy, Bainbridge, D.O.A., Md.		d. STREET ADDRESS 222 Laffay Circle, Manor Heights									
3. NAME OF DECEASED (Type or print) Henry Albert Simmons		4. DATE OF DEATH Month 10 Day 11 Year 1957									
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-13-1879								
9. AGE (In years last birthday) 78 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Civil S. Worker	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
11. BIRTHPLACE (State or foreign country) Pisgah, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Ronnie Simmons		14. MOTHER'S MAIDEN NAME Ida Delozier									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Briel A. Simmons. 222 Laffay Cir. Port Deposit									
17. INFORMANT Manor Heights Address Manor Heights Briel A. Simmons. 222 Laffay Cir. Port Deposit											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by hanging. 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung self to steam pipe in basement.									
20c. TIME OF INJURY Month, Day, Year 10-11-1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Port Deposit, Cecil Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-11-57									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-11-57									
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) Washington, D.C.									
23. FUNERAL DIRECTOR'S SIGNATURE Crehart Mc		24a. REC'D BY REGISTRAR 10-12-57									
ADDRESS Saplatas Md.		24b. REGISTRAR'S SIGNATURE Inene E. Dougherty									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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OCT 16 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10561

10563

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood 12X0.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V.A. Hospital, Perry Point, Md.				d. STREET ADDRESS Emmerton Road			
3. NAME OF DECEASED (Type or print) First BERTIE Middle S. Last STAMPER				4. DATE OF DEATH Month October Day 14 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-00	9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John Stamper			
14. MOTHER'S MAIDEN NAME Mary Blevins				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I			
16. SOCIAL SECURITY NO. 250-013-600				17. INFORMANT VAH, Perry Point, Md. (Hospital Records)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the stomach with widespread abdominal metastases DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from May 10 , 1957, to October 14 , 1957, and that death occurred at 6:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE W. M. Harris M.D. V.A. Hospital, Perry Point, Md. 10-14-57 PHYSICIAN'S NAME (Type) W. M. HARRIS Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10-14-57		22c. NAME OF CEMETERY OR CREMATORY Memorial Gardens		22d. LOCATION (City, town, or county) (State) Belair, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph T. Foster				ADDRESS Foster Funeral Home, Belair, Md.		24a. REC'D BY REGISTRAR DATE 15 1957	
24b. REGISTRAR'S SIGNATURE Jane Dougherty							

BUREAU V.

OCT 15 1957

RECEIVED

10564

CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Bainbridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNTC, Bainbridge, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paul Middle (n) Last Suznovich				4. DATE OF DEATH Month October Day 1 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-14-38	
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond, New York	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Eli Suznovich				14. MOTHER'S MAIDEN NAME Sipos, Helen Rose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1957		17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Sept. 30 , 1957, to Oct. 1 , 1957, that I last saw the deceased alive on Oct. 1 , 1957, and that death occurred at 6:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 10/1/57							
ACTUAL SIGNATURE M L Goodman M.D.							
PHYSICIAN'S NAME (Type) M. L. GOODMAN LT MC USNR				Bainbridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF 10-5-57		22c. NAME OF CEMETERY OR CREMATORY Van Liew Cemetery		22d. LOCATION (City, town, or county) (State) New Brunswick, Middlesex, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee a Patterson & Son, Perryville, Md.				24a. REC'D BY REGISTRAR DATE 10-2-57		24b. REGISTRAR'S SIGNATURE Ernest E Dougherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10563 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10563

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. LENGTH OF STAY IN 1b 22 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital Bainbridge. Md.				d. STREET ADDRESS Manor Heights 113 A Preston Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Genevieve Watson				4. DATE OF DEATH Month Day Year 10 11 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-13-1928		9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Lexington, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Homer M Allender				14. MOTHER'S MAIDEN NAME Geneva Bourne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 405-32-5428		17. INFORMANT Address Charles W. Watson Bainbridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suicide DUE TO (b) Shot self with a revolver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in her home					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11 10 11 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Port Deposit Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/12/57		22c. NAME OF CEMETERY OR CREMATORY Betts & West Funeral Home		22d. LOCATION (City, town, or county) (State) Nicholasville Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wesley Patterson, Son, Perryville, Md.				24a. REC'D BY REGISTRAR DATE 10-12-57		24b. REGISTRAR'S SIGNATURE Gene E. Dougherty	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for 7 days. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. 3

OCT 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10539 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10564

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>North St. McCool Bldg.</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>W</u> Last <u>Wells</u>				4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>12-5-1883</u>			
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u>		IF UNDER 24 HRS. Hours <u>73</u> Min. <u>73</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Elkton, Md.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Clinton Johnson White</u>				
14. MOTHER'S MAIDEN NAME <u>Martha Williams</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				
16. SOCIAL SECURITY NO. <u>220-34-7420</u>			17. INFORMANT <u>Tobias Rudolph</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>331x</u> (c) <u>stating the underlying cause lost.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Elkton</u>		(County) <u>Cecil</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R.C. Dodson</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>10-31-57</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/31/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Elkton Md.</u>		(State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Waller duBois Jr.</u>			24a. REC'D BY REGISTRAR <u>DATE 11/3/57</u>				
24b. REGISTRAR'S SIGNATURE <u>FR Franzer</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

[continued]

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10566 CERTIFICATE OF DEATH

10565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>			c. LENGTH OF STAY IN 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH, Bainbridge, Maryland</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DEBORAH LYNN WOERNER</u>				4. DATE OF DEATH Month Day Year <u>October 12 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-56</u>	
9. AGE (In years lost birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>RISING SUN, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Delmarr LEWIS Woerner</u>				14. MOTHER'S MAIDEN NAME <u>Florence Julia Woll</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Delmarr woerner</u> Address. <u>Rising Sun, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NEPHROSIS, LOWER NEPHRON</u> <u>591X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 4</u> , 19 <u>57</u> , to <u>Oct. 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 12</u> , 19 <u>57</u> , and that death occurred at <u>11:07 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. J. Bise LT, MC, USNR</u>				ADDRESS (Street, city or town, state) <u>U. S. Naval Hospital</u>		DATE SIGNED <u>10/12/57</u>	
PHYSICIAN'S NAME (Type) <u>A. J. BISE LT MC USNR</u>				<u>Bainbridge, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 16, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rising Sun, Cecil, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Sykes</u>				ADDRESS <u>Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 15 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

BUREAU V. S.

OCT 15 1957

RECEIVED

10567 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D. x 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 40				d. STREET ADDRESS Rroute 40.			
3. NAME OF DECEASED (Type or print) First Middle Last (Louis) Lewis J. Wright				4. DATE OF DEATH Month Day Year 10 26 19 57			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-6-1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY House building		11. BIRTHPLACE (State or foreign country) Bloomington, Ind.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Wright				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes W.W.I				16. SOCIAL SECURITY NO. 499-12-3927		17. INFORMANT Mary J. Wright Blkton R.D.1 Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension and Cardiac Disease. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-29-57		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		22d. LOCATION (City, town, or county) (State) North East Rural Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East Md				24a. REC'D BY REGISTRAR DATE 10-29-57		24b. REGISTRAR'S SIGNATURE Larsh E. Rothermel	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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BUREAU V. 1

OCT 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10567

10540

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <u>County Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>4 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>63 Hollingsworth Manor</u>				d. STREET ADDRESS <u>63 Hollingsworth Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Linda</u> Middle <u>M</u> Last <u>Yates</u>				4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>		IF UNDER 24 HRS. Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Daniel Matney</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Ratcliff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>227-22-4157</u>		17. INFORMANT <u>Mr. Aldy Keene, 63 Hollingsworth Manor</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Intestinal Tract.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>153X</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>McClanahan Cem.</u>	
22d. LOCATION (City, town, or county) <u>Stacy, Va.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks, Elkton, Maryland</u>				24a. REC'D BY REGISTRAR <u>10/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>JR Frazier</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 14 1957

RECEIVED